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Audrey Tayse Haynes
Secretary

August 30, 2013

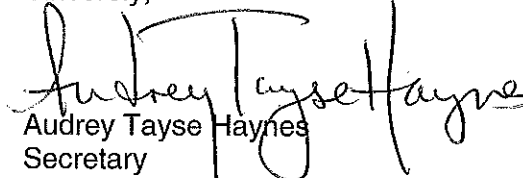
The Honorable Steven Beshear
The Capitol, Suite 100
700 Capitol Avenue
Frankfort, KY 40601

Dear Governor Beshear:

Pursuant to KRS 620.050(12), the Annual Child Fatality/Near Fatality Report from the Cabinet for Health and Family Services, Department for Community Based Services is enclosed.

Should you have any questions, please feel free to contact me at (502) 564-7195.

Sincerely,


Audrey Tayse Haynes
Secretary

Enclosure

pc: Legislative Research Commission
Department for Public Health

Child Abuse and Neglect Annual Report of Fatalities and Near Fatalities

Prepared by:
Division of Protection and Permanency
Department for Community Based Services
Cabinet for Health and Family Services

September 1, 2013

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Introduction

In accordance with KRS 620.050(12), the Cabinet for Health and Family Services (Cabinet or CHFS), Department for Community Based Services (Department or DCBS) submits this annual report of child abuse and neglect fatalities and near fatalities. The report is designed to provide insight into the circumstances that resulted in deaths or near deaths of children who had a protection service history with the Department. The report is organized into four sections: Trends in Child Fatality and Near Fatality Cases; Predicting Child Fatalities and Near Fatalities; Child Fatalities and Near Fatalities in State Fiscal Year (SFY) 2013; and State Program Improvement Efforts. Historical data in this report span the previous five state fiscal years and include only child abuse and neglect fatalities and near fatalities with prior agency involvement.

Historical trend data presented in Table 1 have been updated from the annual report of child abuse and neglect fatalities and near fatalities submitted for SFY 2012. An asterisk indicates that the number has been updated from the prior year's report. The number of child fatalities and near fatalities are subject to change as pending cases are resolved and as coroners complete death investigations and make new reports applicable to a prior fiscal year. Alternately, cases that were initially reported as a near fatality but ultimately ended in death have been updated to reflect the fatality. Additionally, numbers may decrease when an administrative or court hearing overturns an agency determination from substantiated to unsubstantiated. Near fatalities and fatalities that occurred in SFY 2013 are reported as they are reflected in the database at the time of the report. Changes in the 2013 column will be updated in subsequent reports.

Section I: Trends in Child Fatality and Near Fatality cases

In order to establish a context under which child death and serious injury occurs, general child maltreatment data are included in this report. Table 1 provides data on the overall number of child abuse/neglect investigations, the number of those cases where abuse or neglect was found, and the number of fatality and near fatality cases that were the result of maltreatment. Over the past five state fiscal years, the number of reported child abuse/neglect cases has increased by more than 25,000 reports statewide. In SFY 2013, 17,884 children across Kentucky were victims of abuse or neglect.

Table 1: SFY 2009-2013 Fatalities and Near Fatalities that Resulted from Abuse or Neglect, Updated to Reflect the Resolution of Pending Reports or Changes in Findings

	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13
Number of abuse/neglect reports that meet criteria for investigation	33,001	33,362*	32,835	34,706	58,125
Number of children involved in investigations that met criteria	44,992	45,857*	45,104	47,188	54,112
Number of abuse/neglect reports that were substantiated	9,112	9,477*	9,595	9,935	11,288
Number of children involved in cases in which abuse/neglect were substantiated	14,475	15,092*	15,510	15,699	17,884
Number of <i>fatalities</i> in which abuse/neglect was substantiated	29	35*	31	32*	9
Number of substantiated abuse/neglect fatalities with DPP history	15	23*	17*	11*	8
Number of <i>near fatalities</i> in which abuse/neglect was substantiated	60*	51	48*	44*	27
Number of substantiated abuse/neglect near fatalities with DPP history	35	26	25*	28*	17

The small number of child maltreatment cases that result in serious injury or death each year creates significant trend fluctuations and does not provide a representative picture of these cases. However, data from five years provide a sample of adequate size to demonstrate overall trends in child fatality and near fatality cases. In the past five years (SFY 2009-2013), there have been 366 fatalities and near fatalities due to abuse or neglect. Of those cases, 205 (56%) had prior involvement with the Department. Those 205 cases will be the focus of the analysis included in this report.

Gender, Race and Ethnicity of Child Victims

Of the 205 children in this data set whose death or serious injury was the result of abuse or neglect, and with whom the Department had prior involvement, 116 victims (57%) are male. Eighty-nine victims, or 43%, are female. According to the 2011 Administration for Children and Families (ACF) child maltreatment report¹, nationally, 59% of child maltreatment victims were male and 40% were female. Overall in Kentucky, the 2010 US census data indicates males account for 49.2% of the population and females account for 50.7%.

¹ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

Table 2- Percentage of KY child victims by gender for SFY 2009-2013 (N=205)

	Gender of the Victim	
	KY (N=205)	National Percent of Child Abuse and Neglect Victims by gender (ACF 2011 NCANDS Report)
Male	57%	59%
Female	43%	40%

Caucasian children account for 79% of the 205 child fatalities and near fatalities from SFY 2009-2013. African American children account for 13%, and 6% of victims were bi-racial. Table 3 displays the racial and ethnic characteristics of the child victims in Kentucky between SFY 2009 to 2013. Nationally, however, the racial and ethnical distributions of child victims are diverse.

Table 3- Percentage of KY child victims by race/ethnicity for SFY 2009-2013 (N=205)

Race or Ethnicity	Kentucky Fatality/Near Fatality Data (N=205)	2010 Detailed Census Data for Kentucky (N=4,339,367)	National Fatality Data (ACF 2011 NCANDS)
African American	13%	8%	28.12%
Bi-racial	6%	2%	4.7%
Caucasian	79%	88%	40.5%
Hispanic	1%	3%	17.8%
Pacific Islander	0	5%	.1%
American Indian or Alaskan Native	0	1%	1.1%
Asian	0	1%	.7%
Unknown	0	n/a	6.9%

Perpetrator Demographics

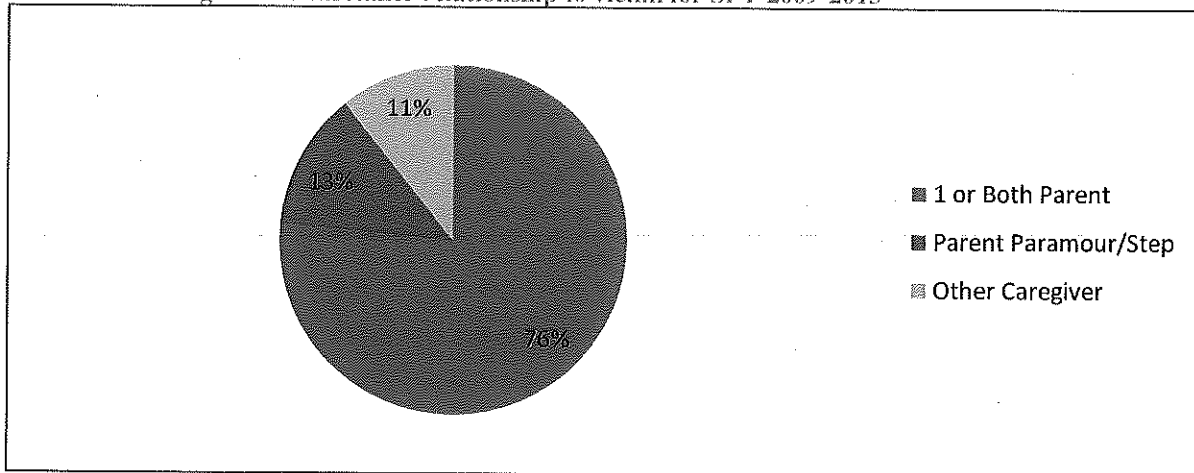
In the 205 cases included in this report, 76% of female perpetrators were age 30 or younger, and approximately 62% of males were 30 years old or younger at the time of the incident. Generally, females who are substantiated as perpetrators in fatal or near fatal instances of abuse or neglect tend to be younger. Male perpetrators, while also tending to be younger, are more evenly distributed along the scale of chronological age.

Table 4- Percentage of KY caretaker by age and gender for SFY 2009-2013 (N=205)

Age of Male and Female Caregivers at Incident (N=205)		
	Male	Female
Under 20	5.0%	16.1%
21-25	30.0%	32.2%
26-30	27.1%	28.2%
31-35	18.6%	7.4%
36+	17.9%	12.8%
Unknown	1.4%	3.4%

Data consistently indicate that parents, acting alone or in collusion with another, are most frequently the perpetrators of fatal and near fatal abuse or neglect. From SFY 2009 through 2013, 76% of fatalities and near fatalities involved a parent as a perpetrator. This trend is also replicated nationally. The federal Administration for Children and Families' most recent report on child maltreatment found parents as perpetrators in fatality cases in 78% of cases.²

Table 5- Percentage of KY caretaker relationship to victim for SFY 2009-2013

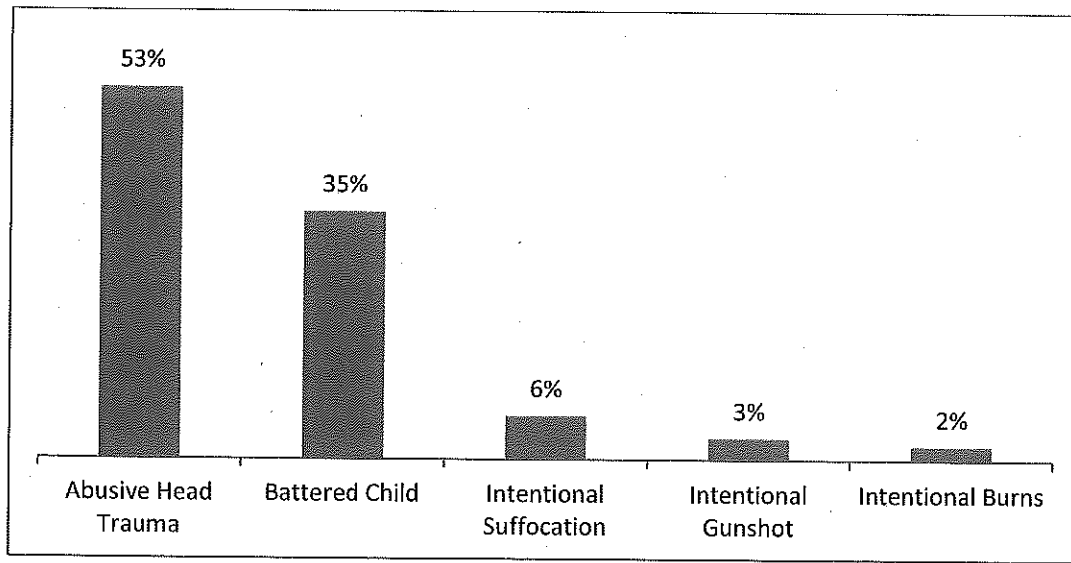


Maltreatment Type

In this analysis, child maltreatment is broken into two categories: physical abuse and neglect. Of the 205 cases, 96 cases were the result of physical abuse, and 109 cases were the result of neglect. Table 6 displays causes of death or serious injury in the 96 physical abuse cases for SFY 2009 to 2013.

² U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

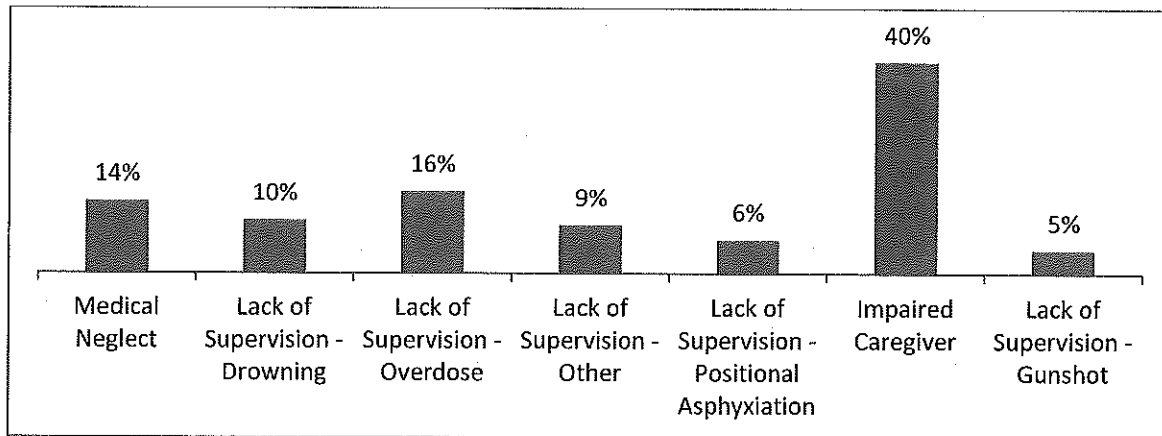
Table 6- Percentage of KY child victims- physical abuse for SFY 2009-2013 (N=96)



Of the 96 physical abuse fatalities and near fatalities in Kentucky over the last five years, the leading cause of death or serious injury is abusive head trauma, which accounts for 53% of injuries resulting from physical abuse. Battered children (or children with multiple injuries) account for 35% of physical abuse deaths or near deaths. Additionally, 6% of victims were intentionally suffocated, 3% died as the result of an intentional shooting, and 2% of victims suffered intentional burns.

For SFY 2009 to 2013, 109 of the 205 total fatalities and near fatalities were attributed to neglect. Table 7 depicts the causes of death or near death. These neglect cases fall into three broad categories: lack of caregiver supervision of the child, impaired caregivers, and caregivers not meeting the medical needs of the child. Impaired caregivers are classified as any incident of death or near death for which the caregiver's substance use or abuse contributed to the incident. This is inclusive of, but not limited to, motor vehicle accidents, lack of supervision due to impairment, or ingestion of illicit substances by the child. The most frequently identified causes of death or near death at 46% were caregivers who did not provide proper supervision, which led to the death or near death incident. This is followed closely by caregivers whose impairment led to the fatal or near fatal event at 40%.

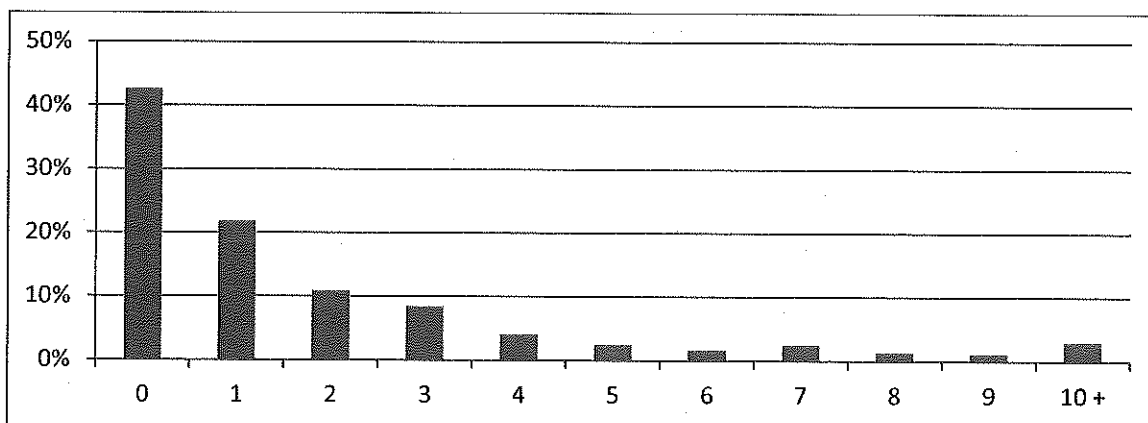
Table 7- Percentage of KY child victims- neglect for SFY 2009-2013 (N=109)



Prior Involvement

In previous years, annual reporting has been consistent regarding fatalities and near fatalities and the number of prior contacts with the agency. Prior involvement is defined as “any assessment or investigation with a child or family in the area of protection and permanency.” Table 8 displays the amount of prior involvement with the child or family and includes all 366 fatal or near fatal incidents of child abuse or neglect from SFY 2009 to 2013. One hundred fifty-six of those 366 incidents, slightly over 42%, did not have prior involvement with DCBS protection and permanency services, and they are not reflected in Table 6.

Table 8- Number of prior investigations or assessments with DCBS protection and permanency in cases of child abuse and neglect related fatalities and near fatalities SFY 2009-2013

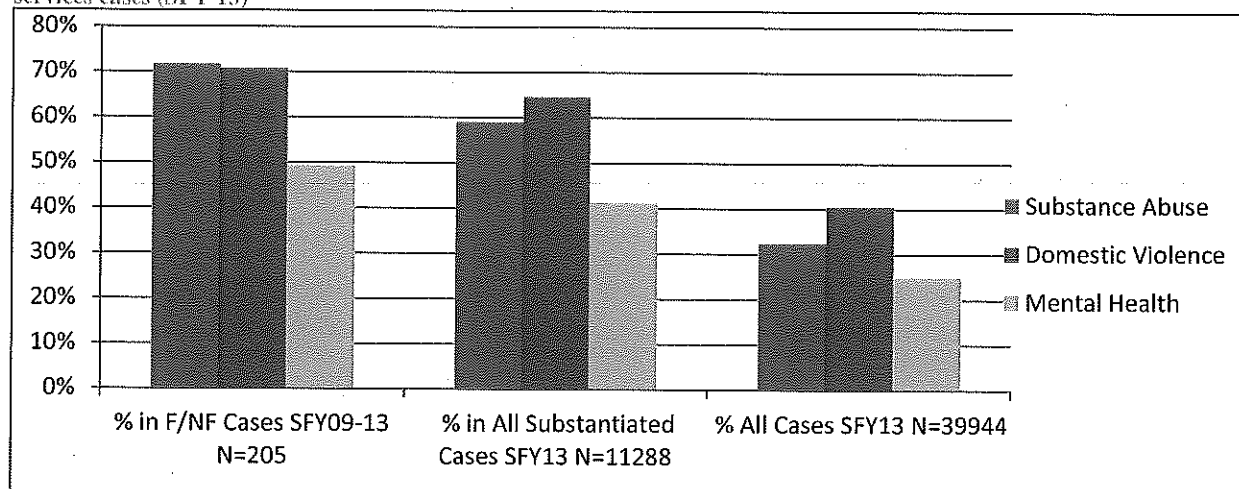


The Administration for Children and Families guidelines define repeat maltreatment as a second substantiation of abuse or neglect within six months of an initial substantiation. For SFY 2009-2013, repeat maltreatment was not present in 94.5% of the child fatalities or near fatalities substantiated by the Department, indicating there was no substantiation in the six months prior to the substantiation of the death or near death incident. Prior involvement is not a measure that distinguishes lethal from non-lethal forms of child maltreatment due to the fact that death.

Household Dynamics

Substance abuse, domestic violence, and mental health issues are commonly known antecedents in child abuse and neglect cases. A similar pattern of risk is present in child fatality and near fatality cases. Table 9 highlights the higher incidence of substance abuse, domestic violence, and mental health issues in cases involving a child fatality or near fatality when compared to all cases that where abuse and neglect were substantiated.

Table 9- Percentage of cases showing evidence of three risk factors: substance abuse, domestic violence and mental health; for cases involving fatalities or near fatalities (F/NF), all substantiated cases (SFY 13) and all child protective services cases (SFY 13)

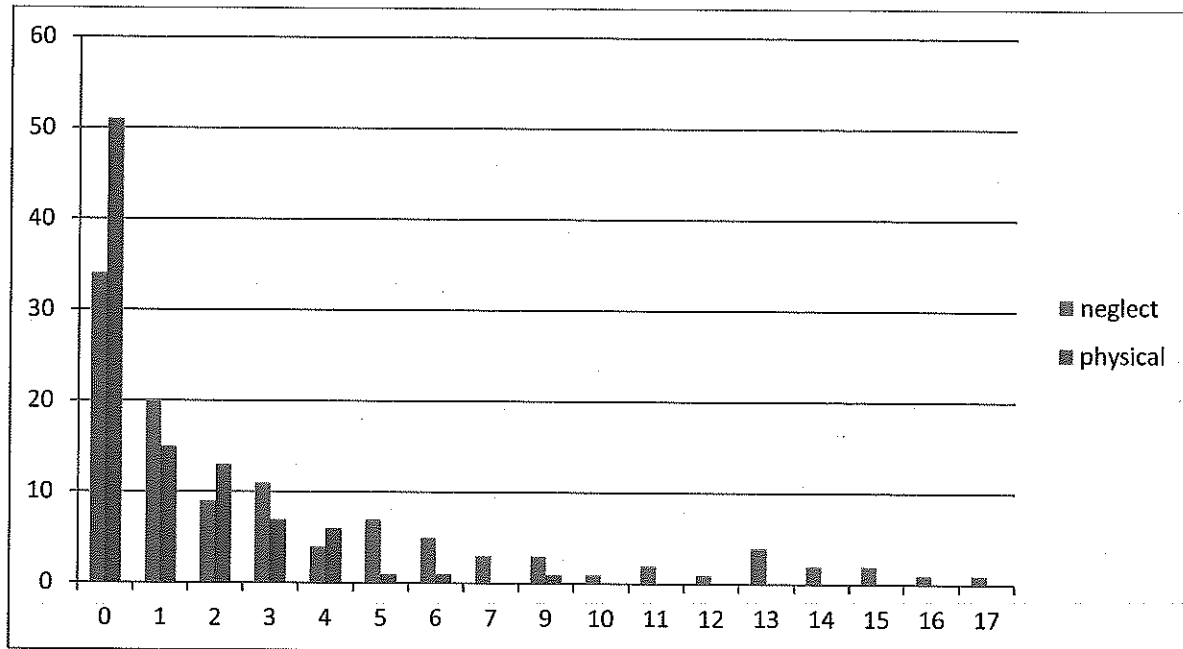


The greater presence of these risk factors in fatality/near fatality cases is more dramatically evident when compared to the over 58,000 Kentucky child protective service cases investigated in SFY 2013. These findings, while consistent with national trends, emphasize the necessity for programs aimed at early identification of these risk factors as well as the need for educational programs designed to reduce these factors and intervention programs to remediate them.

Section II: Predicting Child Fatalities and Near Fatalities

The age of the victim has been the one child demographic that has been consistently useful as a predictive feature for caseworkers and policy makers in cases of fatal and serious child maltreatment. Table 10 displays the percentage of victims by age in the 205 cases for this year's annual report.

Table 10- Percentage of Kentucky children by age for SFY 2009-2013 (N=205)



In Kentucky, 83% of all cases of fatal or near fatal physical abuse involved children less than four years of age. The age of children in neglect-related fatalities or near fatalities is more equally distributed across the age groups. These data show an important relationship between the age of the victim and the type of maltreatment they endure. In recognition of this finding, allegations and case circumstances that affect children age four and younger are evaluated as more urgent in both the initiation and investigative protocol and in the ongoing assessment protocol. Additionally, as part of the investigative and ongoing assessment, protocol is to assess both the child's vulnerability and the parent's capacity to protect the child.

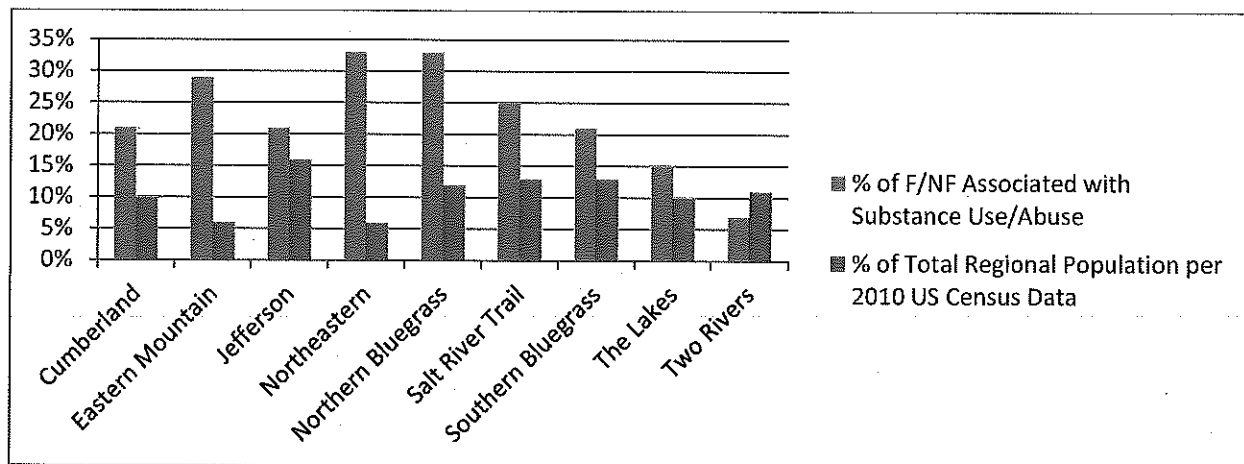
In the 58,125 child maltreatment investigations conducted in SFY 2013, children under four years of age account for fewer than 6% of physical abuse cases that were investigated. On average, physical abuse results in death or serious injury for these young children at a rate of 2.8%. In contrast, children under four years of age that died as a result of neglect represent

only .72% of total neglect cases for children ages four and younger. While there are more instances of deaths or near deaths of children due to neglect, physical abuse resulting in serious injury or death is proportionately more lethal.

Substance Abuse Treatment

The majority of DCBS cases that have substance abuse as a risk factor do not end in fatality or near fatality. Table 12 displays the percent of regional substantiated child abuse and neglect fatalities and near fatalities in which the child or family had prior contact with the agency, and substance abuse or use contributed to the death or near death. Cases are displayed as a percentage of the total number of all regional fatalities in the prior five state fiscal years and are displayed by region in comparison to the regions' population data.

Table 12- Fatality and Near Fatality Cases with substance abuse as a risk factor compared to the regional population



The data in Table 12 highlight that fatality and near fatality cases involving substance use and abuse are occurring in disproportion to the state's population as distributed among the regions. This disproportion may provide some indication that the presence of substance use and substance abuse in fatal and near fatal cases occurs more often in regions of the state where substance abuse recovery and relapse prevention programs are absent or less accessible.

The Department continues to evaluate the constellation of case features present in child abuse and neglect cases that result in fatal or near fatal outcomes. Families involved in the child welfare system present with a myriad of trauma histories and risk factors, including mental health issues, substance abuse histories, unstable living conditions, and a variety of other

household dynamics, such as access to resources and household structures. Understanding the impact of these features remains a work in progress.³ DCBS continues to work with medical, legal, and other community partners to increase our understanding of what situations result in fatal and near fatal child abuse.

Section III: Kentucky Child Fatalities and Near Fatalities in SFY 2013

During SFY 2013, 36 child fatality and near fatality cases were the result of child maltreatment. Of those 36 cases, 25 children or 69% had prior involvement with DCBS. Some specific features of these 25 cases include:

- Nine victims, or 36%, were female. Sixteen victims, or 64%, were male.
- Sixteen victims, or 64%, were four years of age or younger. Ten of those 16 were under one year of age.
- Nine of the cases, or 36%, involved the same perpetrator and the same victim as the previous report.
- Seventeen perpetrators, or 68%, were one or both parents acting alone or with another.
- Ten of the 25 cases, or 40%, were the result of physical abuse, and five of those victims were under age one.
- Sixteen of the 25 cases, or 64%, involved some sort of substance use or substance abuse. Substances ranged from alcohol to opiates and most often involved more than one substance.

Regional Differences

The chart that follows depicts the number of child fatality cases and near fatality cases in each of the nine DCBS service regions during SFY 2013. See Appendix A for a regional map of counties in each service region.

³ Reference : "Predicting child fatalities among less-severe CPS investigations." J. Christopher Graham, Kelly Stepura, Donald J. Baumann , Homer Kern. Children and Youth Services Review. 2010: 32 (274–280)

Service Region	# of abuse/neglect fatalities with prior involvement	# of abuse/neglect near fatalities with prior involvement	Total fatality/ near fatality with prior involvement
Cumberland	1	3	4
Eastern Mountain	1	1	2
Jefferson	3	5	8
Northeastern	0	1	1
Northern Bluegrass	1	3	4
Salt River Trail	0	1	1
Southern Bluegrass	0	1	1
The Lakes	0	0	0
Two Rivers	2	2	4
Statewide Totals	8	17	25

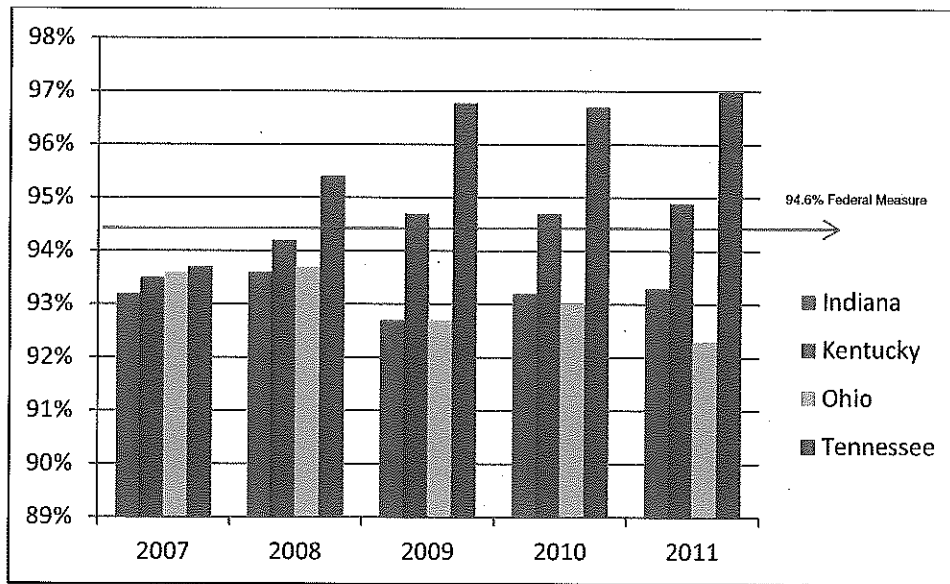
Section IV. Kentucky's Program Improvement Efforts

The Department engages in a variety of quality assurance activities aimed at driving program improvements. DCBS utilizes a comprehensive and standardized case review tool and a random standardized case analysis process for quality assurance purposes. The Department uses data collected during case reviews to inform decision making in the areas of policy, practice, and training.

Federal Repeat Maltreatment Measures

The Department is required annually to report data to ACF on repeat maltreatment in both fatal and non-fatal child protection cases. ACF considers repeat maltreatment to mean that the family had a second substantiation of child abuse or neglect within six months of the state agency's first substantiation. Table 11 demonstrates the percentage of families that did not have a second substantiation within six months for all abuse and neglect cases. Table 11 also displays Kentucky's performance in comparison to that of neighboring states.

Table 11- Absence of repeat maltreatment compared to contiguous states



The single horizontal line at 94.6 percent represents the national standard for this indicator. States strive to be above this line. The most current data available for this indicator shows Kentucky performing at a rate of 94.9%^[1].

Internal Reviews

The internal review process is mandated by KRS 620.050(12) and asserts that the Cabinet hold an internal review whenever there is a substantiated death or near death case, and the Cabinet has prior involvement with the child or family. Prior involvement is defined by 922 KAR 1:420 as “any assessment or investigation, of which the cabinet has record, with a child or family in the area of protection and permanency prior to the child’s fatality or near fatality investigation.” The purpose of the internal review is to review the agency’s prior intervention and identify areas of improvement.

There were 25 cases that required an internal review that are included in this report. In order to better understand the opportunities for improvement, issues were organized into nine basic areas:

Lack of documentation- defined as “work was completed correctly, but not captured in the documentation”;

Lack of Knowledge of Standards of Practice (SOP)- defined as a “lack of understanding basic SOP guidelines related to a specific aspect of work”;

Risk Assessment- defined as “inability to identify protective factors, risk factors, and/or safety factors”;

Community Relations- defined as “difficulty in partnering and/or communicating across agencies”;

Lack of Resources- defined as “services were identified and needed, but not available in the service area of the family”;

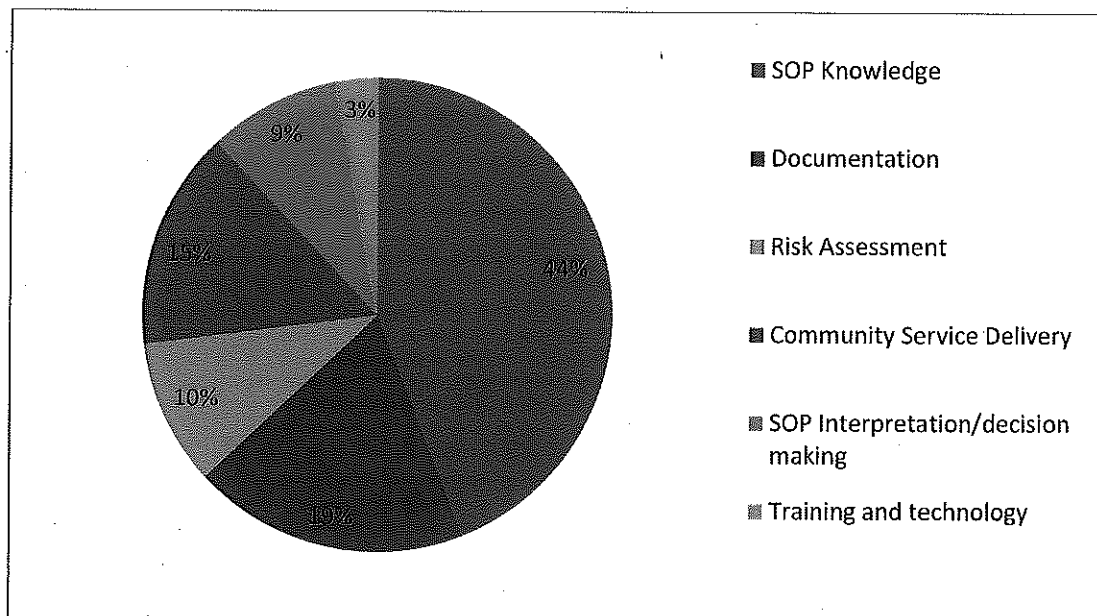
SOP interpretation/decision making- defined as “inability to apply and integrate information gathered in a risk assessment”;

Training- defined as “an identified need or request for information not related to specific policy”;

Technology- includes issues with The Worker Information System (TWIST), the network, and other technology.

The majority of issues identified during the internal review process revolved around SOP knowledge (44%) or lack of documentation (19%). Community relations and lack of resources were identified in 15% of cases as being an issue. Table 16 displays the distribution of all issues identified during internal reviews that had an impact on the outcome of either the prior protection and permanency work with the family or the fatality/near fatality investigation.

Table 16 Displays the Categories Identified in Internal Reviews



The Department continues to conduct internal reviews and is implementing additional reviews for all fatality and near fatality cases if there is previous history, regardless if the death or near death is substantiated, by conducting policy reviews on the last 18 months of history. The goal of this effort is to identify trends related to policy knowledge and application in order to provide effective training and, in some instances, clarifications to policy.

Trainings and Research

The Department utilizes information gained during internal reviews to implement trainings to enhance knowledge and skills of staff. The Department also conducts additional case reviews in order to understand the complex factors present in the families and children served by the agency.

- *"Bruises and Patterned Injuries"* is a training that is presented by a Central Office Fatality Nurse. This training provides information on types, locations, and variations of bruises and other skin injuries to community partners, the Community Collaborations for Children (CCC) Regional Networks, DCBS supervisors and staff, and medical professionals. The purpose of the training is to provide information to these individuals to heighten awareness of abusive injuries. Several sessions of this training were held around the Commonwealth during SFY 2013, including five sessions with the Appalachian Regional Hospital Emergency Department staff.
- *"Burns – Accidental or Inflicted"* is a training that is presented by the Central Office Fatality Nurse on the different types of burns and burn patterns. Several session of this was offered in SFY 2013, including five sessions with the Appalachian Regional Hospital Emergency Department Staff, in addition to presentations to other community partners.
- *"The Effects of Parental Substance Abuse on Children"* is a training that DCBS provides to DCBS staff, community partners, Family Resource/Youth Service Centers staff, and the CCC Regional Networks. The goal of this training is to educate individuals on the negative effects substance abuse can have on children.
- *"Dynamics of Domestic Violence"* is a training developed by DCBS to inform the public on the indicators and elements of homes with violence. This workshop is presented to community partners around the Commonwealth.
- *"Medical Elements of Child Abuse and Neglect" (MECAN)* is a series of medical trainings designed for the non-medical professional to provide information on a variety of medical topics. It was developed with the assistance of Dr. Melissa Currie, Director of the Division of Pediatric Forensic Medicine at the University of Louisville. Nine courses are currently available on a variety of medical issues related to child maltreatment. Several trainings have been converted to modules on the KYTRAIN network, administered by the Department for Public Health, for access by both DCBS staff and community partners. The goal of the training is to increase recognition of medical indicators of abuse and neglect for staff, supervisors, and community partners. This training is presented several times per year.

- *"Drug Summits: Child Welfare Decision Making"* has been a training provided to frontline staff, supervisors, and management. In fall 2011, the Drug Summits purpose was to help staff think differently about families who have the co-occurring issues of substance abuse and child maltreatment. The training addressed personal values having to do with substance abuse and provided education on addiction as a disease and disorder of the brain. Staff learned about the continuum of substance use disorders (i.e., use, abuse, dependency) and was trained on specific drugs and their effects. Drug testing was addressed during this training, and staff had the opportunity to build skills by "working" a case during the afternoon session. Areas of focus during this segment included safety and risk factors related to substance abusing families, prevention planning, case planning, relapse prevention planning, and reunification with substance abusing families. Four Drug Summit sessions are planned for October 2013 in the following service regions: The Lakes, Southern Bluegrass, Northern Bluegrass, and Jefferson.
- *"Mandated Reporting"* training has been provided to each local DCBS office on CD and has become available on KYTRAIN network for community partners. This module can be utilized by DCBS staff when presenting to civic groups and community partners. Information is included on acceptance criteria, how to make a report, and the process for taking and initiating a report and services. The goal of the training is to increase community understanding of mandated reporting requirements. To date, approximately 254 community agency partners have been trained.
- *"Recognition and Documentation of Abusive Injuries"* is a workshop first presented at the annual meeting of the Kentucky Nurses Association, as well as workshops for victim advocates and prosecutors sponsored by the Office of the Attorney General and the Justice and Public Safety Cabinet. The workshops were designed to increase community understanding of child abuse and neglect. This workshop was presented in May 2013 during a Forensic Interviewing Training in Lexington, KY.
- *"Substance Exposed Infants for Child Care Providers"* is a workshop that was developed to educate child care providers on the challenges of providing for substance exposed infants. Infants born exposed or addicted to substances pose unique challenges to care providers. This workshop aims to arm child care providers with the knowledge of how to care for these special children.
- *"Pediatric Abusive Head Trauma"* is a mandatory 1.5 hour training required by law enacted during the 2010 General Assembly for various professionals in the child welfare, legal, and medical communities. The training was developed by Dr. Melissa Currie and DCBS' Child Fatality Nurse Service Administrator for statewide implementation. At least eight different sessions of this training were offered in SFY 2013 and targeted specifically at guardian ad litem (GALs), social workers, child care providers, court personnel, and community partners. In addition, it was a workshop offered at the Kentucky Alcohol and Other Drug School at Northern Kentucky University in July 2012.

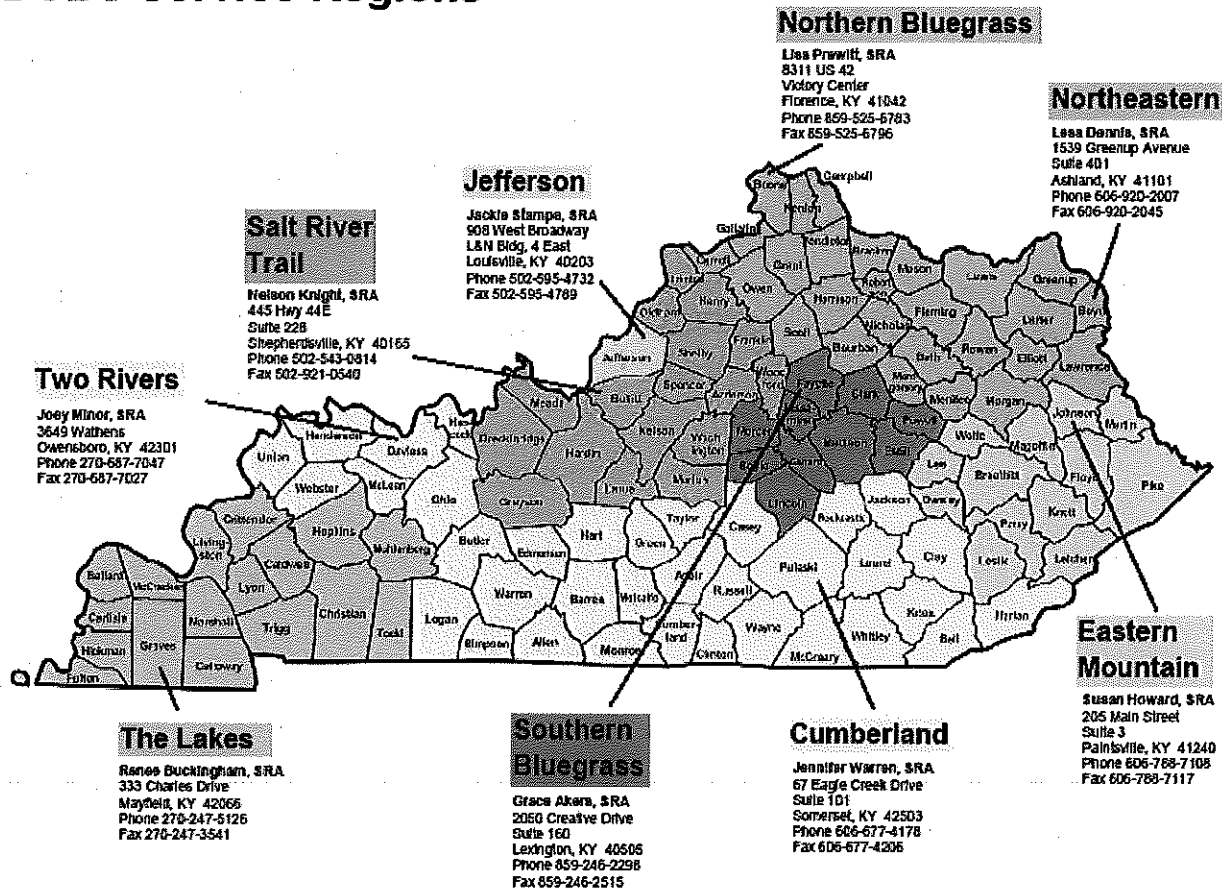
Initiatives and Programmatic Improvements

The Department has also undertaken various initiatives and program improvements as a result of internal review and case reviews.

- The Division of Forensic Medicine (DFM) in the Department of Pediatrics at the University of Louisville provides forensic consultations and medical evaluations of child victims of physical abuse. The collaboration between DFM and DCBS assists staff who are completing and documenting child protective services investigations. The Division of Forensic Medicine also provides court testimony, when warranted, and assists the Child Fatality Nurse Service Administrator on cases of physical abuse as needed. This collaboration assists DCBS in differentiating inflicted injury from accidental trauma. Approximately 551 referrals for consultations have occurred over the past state fiscal year.
- The Four and Under High Risk Consultation Model continued for SFY 2013. Third-level, continuous quality improvement case reviews were conducted on these cases monthly throughout the state fiscal year. The data obtained from these reviews have provided DCBS guidance on where to focus improvement in the quality of risk assessment. The model underwent a program evaluation in fall 2012, and another is scheduled for late 2013. DCBS is continuing to evaluate outcomes to direct practice in this area.
- As a result of an earlier evaluation of the four and under case reviews, a new investigative assessment tool is being implemented to guide case decision-making. This new tool features prompts for risk and protective factors as well as prompts for a more thorough assessment of caretakers. It will assist staff to better assess safety and risk in a family while focusing on parental capacities. It is anticipated the new investigative assessment tool will be rolled out statewide in early 2014.
- In collaboration with Dr. Melissa Currie and the University of Louisville's Department of Forensic Medicine, DCBS is in the process of revising the acceptance criteria for physical abuse referrals on children aged four and younger. The new acceptance criteria will guide centralized intake workers when taking these referrals to ensure they are appropriately screened for acceptance. It is expected the new acceptance criteria will be implemented in fall 2013.
- The External Child Fatality and Near Fatality Review Panel was enacted by the Kentucky General Assembly during the 2013 Regular Session and became effective June 25, 2013. This panel will receive copies of all child fatality and near fatality cases, both substantiated and unsubstantiated, with and without prior DCBS history.

Appendix A. Regional Map

DCBS Service Regions



August 1, 2012

Appendix B. Data Tables

AGE OF CHILD N=205	SFY 2013 N=25		SFY 2009-2013 TOTALS
	Fatality	Near Fatality	
Under 1 yr	4	6	85
1 year	0	1	35
2 years	1	2	22
3 years	0	0	18
4-6 years	3	3	24
7-12 years	0	3	11
13-17 years	0	2	10
Total	8	17	205

GENDER OF CHILD	SFY 2013		SFY 2009-2013 TOTALS
	Fatality	Near Fatality	
Male	6	10	116
Female	2	7	89
Total	8	17	205

RACE OF CHILD	SFY 2013 N=25		SFY 2009-2013 TOTALS
	Fatality	Near Fatality	
African American	3	3	27
Bi-racial	1	0	13
Caucasian	4	14	162
Hispanic	0	0	2
Unknown	0	0	1
Total	8	17	205

TYPE OF MALTX	SFY 2013		SFY 2009-2013 TOTALS
	Fatality	Near Fatality	
Physical abuse	4	11	96
Neglect	4	6	109
Total	8	17	205

RELATIONSHIP OF PERP TO VICTIM	SFY 2013		SFY 2009-2013 TOTALS
	Fatality	Near Fatality	
Mother	1	6	42
Father	3	2	38
Both parents	1	2	36
Parent and other	2	0	41
Paramour	0	4	26
Other	1	2	17
Unknown	0	1	5
Total	8	17	205

CAREGIVER RISK FACTORS*	SFY 2013	SFY 2009-2013 TOTALS
Substance Abuse	16	147
Domestic violence	19	145
Mental Health	15	101

*multiple risk factors are present in most cases; therefore, these data will overlap

AMOUNT OF PRIOR HISTORY (FATALITY AND NEAR FATALITY CASES)	SFY 2013	SFY 2009-2013 TOTALS
1 prior report	6 cases	80 cases
2 prior reports	4 cases	37 cases
3-5 prior reports	9 cases	54 cases
6-9 prior reports	5 cases	24 cases
10 + reports	1 case	10 cases
Total	25	205

Relationship of Perpetrator to Victim KY (N=205)	
Father	19%
Mother	20%
Both Parents	18%
Parent and Another Person(s)	20%
Parent Paramour	13%
Another Relative	6%
Unrelated Caregiver	2%
Unknown	2%